This form may be completed online, printed and mailed to the address listed below.

08/02

Please type or print: **NURSE AIDE REGISTRY FORM** Date _____

If applicable, please check only ONE of the following:

Nursing Student ☐ Interstate Endorsement ☐ State Trained ☐ Military ☐

SOCIAL SECURITY NUMBER _____

NAME _____
(Last) (First) (Middle)

MAIDEN NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____ Apt. # _____

CITY _____ STATE _____ ZIP _____

FACILITY/AGENCY WHERE EMPLOYED _____
(Facility/Agency) (City)

DATE HIRED _____

FACILITY TELEPHONE #: _____

NAME OF FACILITY EMPLOYEE COMPLETING THIS FORM _____

ABUSE INSERVICE DOCUMENTATION

In accordance with Title 175 NAC 13, this verifies that:

_____ _____
Name (please type or print) Social Security Number

received at least one (1) hour of training in procedures for reporting suspected abuse or neglect, including:

004.02C1 The requirements of Nebraska Revised Statute 28-372.
004.02C2 Residents' rights as set forth in 175 NAC 8-003.02F and 175 12-003.02F.

Facility/City _____ Date of Inservice _____

_____
RN Instructor's Signature

Please return this form to: **Department of Health & Human Services**
Regulation and Licensure - Credentialing Division
P.O. Box 94986
Lincoln, NE 68509-4986